MILITARY MEDICAL ETHICS

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SECTION I: MEDICAL ETHICS

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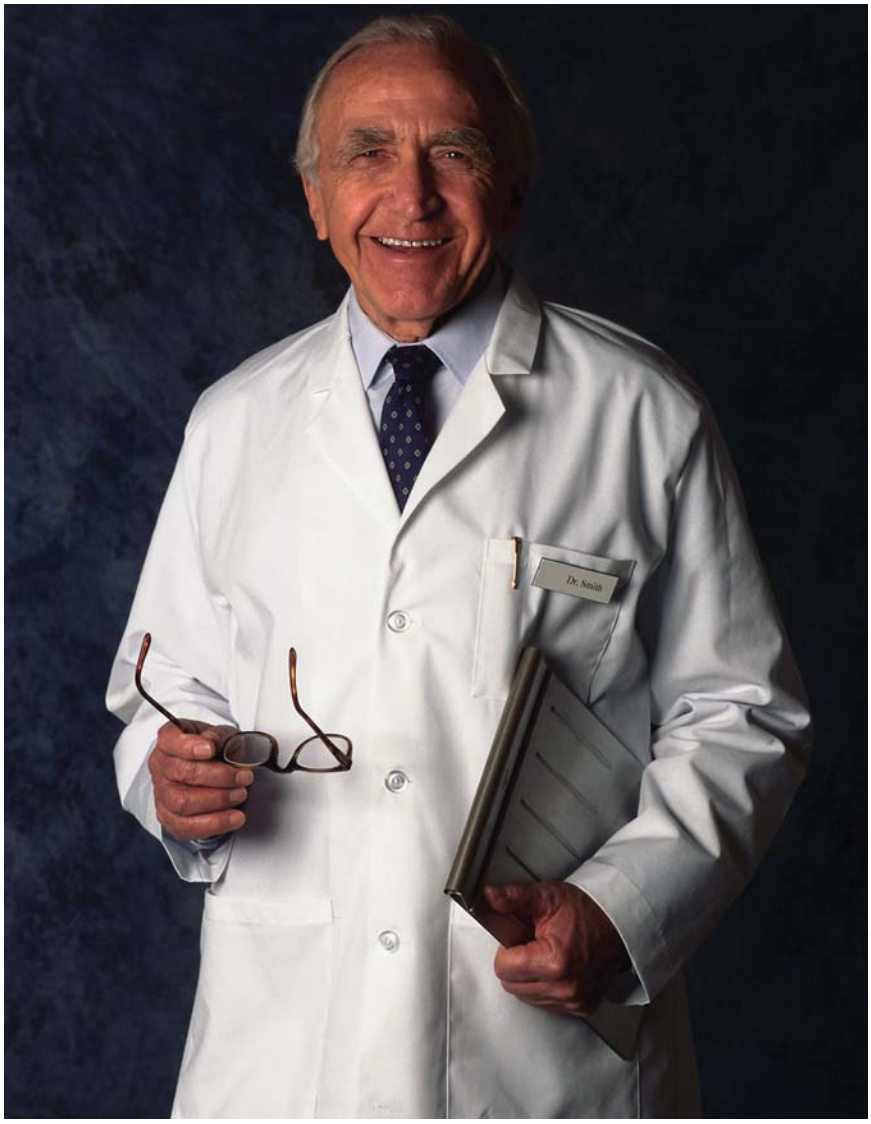

Kindly Doctor

Chapter 1

THE MORAL FOUNDATIONS OF THE PATIENT–PHYSICIAN RELATIONSHIP: THE ESSENCE OF MEDICAL ETHICS

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Photograph of a relief of *The Manifestation of Asclepius During Incubation.* The "model," or idealized, patient–physician relationship: a patient who is ill and a physician who offers to help. Models of the patient–physician relationship have been developed throughout the history of medicine and have shaped the way physicians and patients have confronted each other. These models in each era have been the result of a fusion of three elements: (1) a philosophy of medicine, (2) the ethos or dominant spirit of medicine itself, and (3) the linkage between these first two elements and some philosophical school. These elements relate to each other in different ways and often recur from era to era, but throughout the eras models often bear resemblance to one another because there is some facet of truth in each that reflects the complexity of the human relationship between one who professes to heal and one who is in need of healing.

INTRODUCTION

In medicine, whether in the civilian or military setting, medical ethics begins and ends in the patient–physician relationship. The conception we hold of that relationship shapes the decisions we make in every clinical situation. It sets the standard for right and wrong, good and bad professional conduct. It is the final arbiter of the moral status of every policy affecting the health of individuals or the public. Even public health, military, and penal medicine, which incorporate societal goals, must balance those goals against the realities of the relationship of a patient and a physician. How we see that relationship will determine the kind of society we are, have become, or want to be.

For these reasons, this first chapter is devoted to the moral foundation of the conduct of the patient–physician relationship. Such a foundation, if it is to be adequate as the keystone of the edifice of medical ethics, must at a minimum answer certain key questions: Is there anything morally special about the patient–physician relationship, and if there is, what is it? What does the special nature of the relationship entail with respect to the duties physicians and patients owe each other, the virtues they should exhibit, or the rules, principles, and attitudes that should guide their interactions in the clinical encounter? These questions are implicit in the later chapters, which define the special nature of the patient–physician relationship in the clinical and the military context.

This chapter confines itself to the ethical aspects of the patient–physician relationship. Its focus therefore is on professional ethics—the ethics of the physician as a professional (and, by analogy, to other health professionals, eg, nurses, dentists, clinical psychologists, social workers). The content of bedside ethical decisions—the ethics of particular clinical dilemmas—is discussed in later chapters. The religious and theological foundations of medical ethics are not included, even though, for many Americans, they are the ultimate source of all morality, in general or in the professional life. Finally, we must not forget that patients and physicians meet each other in an intricate matrix of psychosocial, cultural, and sociohistorical phenomena that can modify the expression of medical ethics.[1] These factors notwithstanding, there is a foundation for the duties of all health professions that is relatively constant across cultures, history, and national boundaries.

IS A FOUNDATION FOR MEDICAL ETHICS POSSIBLE?

Historically, the Hippocratic Oath (Exhibit 1-1) and ethos were not universally accepted as the foundation for medical ethics by most ancient Greek physicians.[2–4] They originated with a small group of physicians who were eager to distance themselves from the majority of their contemporaries who were itinerant journeymen, businessmen, and craftsmen. In later antiquity, the Hippocratic ethic found favor with the three monotheistic religions and, through their influence, became widely disseminated.[5–7] At least from the late Middle Ages on, and well into the modern era, the moral precepts of the Hippocratic ethic were the standard for the ethical conduct of physicians.[8]

Our concern is not with the evolution of medical ethics as an historical or social epiphenomenon. It is the deeper moral phenomena upon which it has been based that are of importance. It is the existence of these phenomena, which the Hippocratic physicians and their successors grasped intuitively, that accounts for the durability of their ethic across so many centuries, countries, and cultures.

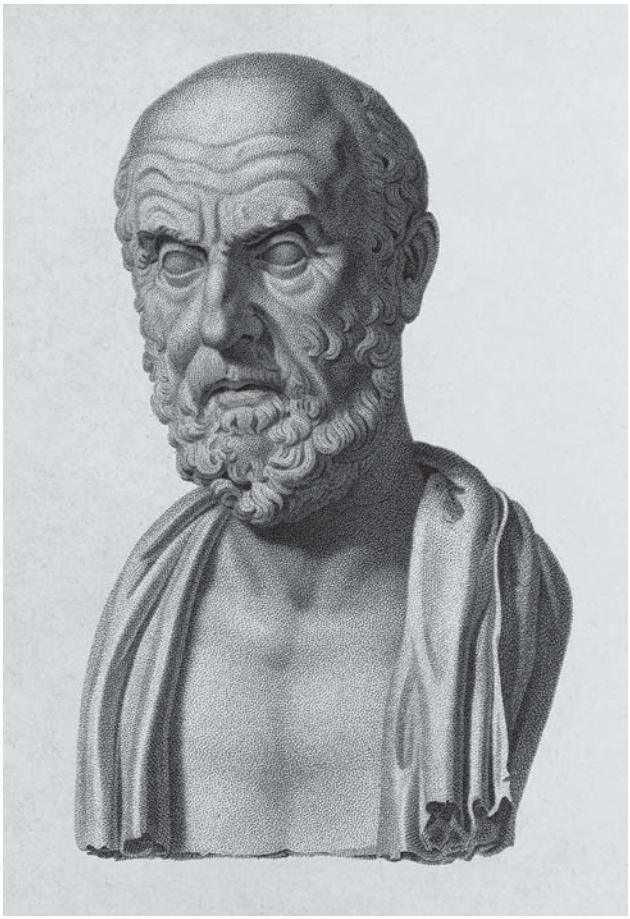
A quarter of a century ago the question of whether or not a foundation for medical ethics was possible would have seemed a naive question. At that time the Hippocratic ethics, exemplified by the oath, the so-called "deontological" books of the Hippocratic Corpus (dealing with the oath, precepts, the law, decorum, and the physician),[9,10] and its congeners in the Code of the American Medical Association (AMA)[11] and dozens of other codes of medical ethics and variations,[12] were taken for granted as the source and foundation for the ethics of the patient–physician relationship. Today this foundation is no longer secure. An increasing number of ethicists, physicians, and even the public, believe not only that the Hippocratic ethic is out-of-date but that the whole idea of a stable foundation for ethics is no longer tenable.

Several challenges singly, and in combination, have brought about this present state of affairs. Four that seem most important are: (1) the upheaval in social values in the 1960s; (2) the interest in medical ethics by professional philosophers; (3) the transformation of medical ethics into "bioethics"; and (4) the "postmodern" turn of philosophy in general, and moral philosophy in particular.

The first serious contemporary challenge to the Hippocratic foundation was sociopolitical. Beginning

EXHIBIT 1-1

THE OATH OF HIPPOCRATES



I swear by Apollo Physician and Asclepius and Hygieia and Panaceia and all the gods and goddesses, making them my witnesses, that I will fulfil according to my ability and judgment this oath and this covenant:

To hold him who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them this art—if they desire to learn it—without fee and covenant; to give a share of precepts and oral instruction and all the other learning to my sons and to the sons of him who has instructed me and to pupils who have signed the covenant and have taken an oath according to the medical law, but to no one else.

I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice.

I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. In purity and holiness I will guard my life and my art.

I will not use the knife, not even on sufferers from stone, but will withdraw in favor of such men as are engaged in this work.

Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons, be they free or slaves.

What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself holding such things shameful to be spoken about.

If I fulfil this oath and do not violate it, may it be granted to me to enjoy life and art, being honored with fame among all men for all time to come; if I transgress it and swear falsely, may the opposite of all this be my lot.

Reproduced with permission from: Edelstein L. *The Hippocratic Oath: Text, Translation and Interpretation.* In: Sigerist HE, ed. *Bulletin of the History of Medicine,* Supplement 1. Baltimore, Md: The Johns Hopkins Press; 1943: 3. Artwork © Bettmann/CORBIS; reproduced with permission.

in the late 1960s in America, for various reasons (as discussed further in Chapter 3, Clinical Ethics: The Art of Medicine), all traditional values and sources of moral authority were challenged—religion, the family, parents, teachers, all holders of authority, and all the professions. This was the era of participatory democracy, which saw the rise of the consumer movement, civil rights legislation, the Patient's Bill of Rights, and a rash of student protests against academic tradition and authority. In such a climate physicians, medicine as a privileged profession, and medical ethics were especially vulnerable. They were seen as elitist, monopolistic of power, and self-aggrandizing.

The second challenge came from professional philosophers who for the first time in their history took a serious interest in medical ethics. To be sure, the ancient philosophers often referred to medicine, but neither they nor their modern counterparts ever wrote serious treatises on medical ethics. Only in the last quarter of the 20th century did philosophers examine the moral presuppositions of the traditional ethic. They did so using the conceptual tools of a variety of established moral systems. Each system introduced its own perspective on the relationships between physicians and patients. For example, the followers of the philosophy of Kant, placed their emphasis on patient autonomy; those who followed J.S. Mill chose utility maximization; and followers of W.D. Ross turned to prima facie principles (see Chapter 2, Theories of Medical Ethics: The Philosophical Structure). As a result, the Hippocratic tradition of benevolence and beneficence was reinterpreted as authoritarian, insensitive to social ethics, and even unjust. Other major precepts, such as the prohibitions against abortion, breaches of confidentiality, and sexual intercourse with patients, were relaxed. Currently, the prohibitions against assisted suicide[13] and euthanasia are under attack. Pressures have steadily mounted for an oath and code more congruent with contemporary mores.[14,15]

The third challenge arose out of the progressive intrusions into medical ethics by law, politics, economics, psychology, and culture. Beginning in the 1980s, a larger view of medical ethics emerged under the new rubric of "bioethics." Bioethics extended beyond the bedside to social and public policy, ecology, and the environment. In the 1990s scholars in the social sciences entered this broader field. Those outside the field of philosophy challenged philosophical ethics as a rational discipline. They judged it too abstract and insufficient to encompass the full complexity of the moral life. Alternative theories and models of ethics such as casuistry, narrative, virtue, feminist, and caring ethics have been proposed.[16] To remedy these presumed deficiencies, ethics itself has often been reduced to issues of public policy and procedure rather than patient–physician relationships.[17]

The fourth challenge in the erosion of traditional medical ethics arose in the attack on philosophical ethics by the "postmodern" critique of philosophy itself. This critique centers on the claims of reason, itself, to arrive at moral truth. The postmodern critique challenges the traditional pretensions of philosophy to achieve moral truth through reason alone. Postmodernism declares philosophy to be "dead."[18,19] Secular bioethics is particularly vulnerable to this critique because it built its endeavor on the post-Enlightenment project of ethics free of metaphysics and religion and dependent only on an autonomous rationality. Postmodernism has become a "deteriorated version of the Enlightenment."[20(p20)] Postmodernism deprives contemporary bioethics of its rationalist underpinnings and denies it access to any foundation or overarching theory. In this view, any foundation for medical ethics such as the Hippocratic ethic, or the one this chapter shall describe, is ipso facto intellectually suspect.

This surely is not the place to attempt the complex task of refutation of the postmodernist thesis. But as Rosen argues, postmodernism reduces philosophy to ideology. This places the ideology of linguistic fashion in the place formerly occupied by philosophy.[19,20(p176)] We may try to eliminate foundations, but there is always a position of last resort beyond which we cannot retreat. Call it what we will, this position of last resort is in fact a "foundation." Thus antifoundationalism is the postmodernists' position of last resort.

What is of relevance to this chapter is that contemporary medical ethics faces an important choice with very practical consequences. (For a more detailed discussion of postmodernism and deconstructionism, please see Chapter 3, Clinical Ethics: The Art of Medicine.) If medical ethics chooses to go the postmodernist route, it must accept a variously interpreted and deconstructed ethic, one malleable by social and linguistic construction. Profession and patients will fragment further and further into smaller and smaller communities with different and contradictory moral values.[21] A uniform set of moral precepts binding all physicians will no longer be possible. Each therapeutic encounter will become a new negotiable event with its own rules, duties, and principles, or the whole of bioethics will be left to social consensus.[22] Any notion of a foundation for ethics based in respect for human life will be replaced by a technological determinism.[23]

This chapter takes a different pathway—the way of reconstruction of the ethical foundation for medical ethics, not its deconstruction. This does not imply a simplistic reaffirmation of the Hippocratic ethic. A true "reconstruction" means retaining what is valid in the old and enlarging it by new insights. This is not the same as changing ethics to accommodate to social mores. The beginning, a quarter century ago, of formal philosophical reflection on the Hippocratic moral precepts, uncovered a genuine need for their justification beyond mere assertion. This has been salubrious because it changed

medical ethics from a set of free moral assertions into a respectable ethical enterprise. This chapter undertakes a reconstruction of medical ethics out of the empirical phenomena of the clinical encounter and the experiences of illness and healing. These are the universal phenomena that underlie the relationships of patients and physicians across temporal and cultural barriers. These are the relationships perceived by the Hippocratic physicians but never formally or systematically argued.

SOME CURRENT MODELS OF THE PATIENT–PHYSICIAN RELATIONSHIP

Medicine is a multivaried societal phenomenon in which physicians may play a variety of roles simultaneously. Each role elicits a particular kind of relationship with the patient and entails a particular kind of ethic. One of these roles, the role of healer, is primary; the others are subsidiary. Before turning to the reconstruction of this primary role, it is important to examine some of the alternative models and the ethics they entail. Pedro Lain Entralgo has written most perceptively about the history of the patient–physician relationship.[24,25] He summarizes the relationship in terms of the physician's motives under four general headings: (1) physician as technical helper; (2) physician as seeker of knowledge; (3) physician as functionary of an institution; and (4) physician as a seeker of profit.[24] Elements of these motives are intermingled in each of the more specific models to be examined below.

The Physician as Clinical Scientist

One prominent model, often emphasized in medical schools, is the patient–physician relationship as an exercise in applied biology.[26] In this model, the relationship is a means for attaining knowledge and also for applying existing knowledge to solve a patient's diagnostic or therapeutic problem. The ethic governing this kind of relationship is the ethic of good science, the rules of which are objectivity, honesty in recording data, technical competence, and so forth. The patient is the object of study seen as a concrete instance of the universal laws of biology and pathology. This model does not deny the existence or importance of psychosocial and personal elements in the genesis or treatment of the illness. But these elements are not considered properly as in the domain of medicine or the physician. They belong to social workers, psychologists, and pastoral counselors. It is the physician's task to take note of these subjective elements but to refer them to others for treatment.

The Physician as Body Mechanic

A variant of this model of the physician as clinical scientist is to see the patient–physician relationship as a mechanical event equivalent to the owner of a defective automobile bringing it in for repair or replacement of a part.[27] In this model, the physician is the mechanic and the patient is the owner of a part to be fixed. Psychosocial and personal elements are really irrelevant. Because they are not mechanically fixable, they are not part of the physician's task. The ethic of this relationship is the ethic of technical competence, impersonality, and fulfillment of a service contract.

The Physician as Businessman

In the business model, healthcare is a commodity to be bought and sold on the open market for profit.[28] Its price, availability, distribution, and quality are dependent upon competition. The patient is a consumer who shops for care as he shops for other needed goods. The patient is a source of gain for the physician who competes for patient "business." The ethic in this model is the ethic of business and the "ethic" of the marketplace. In the market, patients are players whose welfare depends upon what they can command in the way of resources and what they can negotiate in trade. Solicitude or concern for the "loser" is important only if it makes for better business. If someone makes a wrong choice, or lacks the wherewithal to enter the market in the first place, this is unfortunate but not the concern of the physician, or those for whom the physician works.

Two variants of the market relationship model are the entrepreneur and the managed care models.[29,30] These roles may be combined when physicians are simultaneously caregivers, "providers," and investors, owners, or risk-sharers in managed care organizations or healthcare facilities. Here providers compete for capitation contracts to provide care for large target populations, preferably those with few medical needs who will pay their premiums and will not need much in the way of care. The physician is an employee of an organization or one of its owners. The dominant ethic is the ethic of competitive business and corporations. This is a minimalist ethic always at risk of compromise if profit margins drop. The patient becomes a cus-

tomer and client, a source of gain, or a unit of care—an "insured life" who can be "traded" in mergers or contract negotiations.

In these technical and market models, the physician regards the practice of medicine primarily as an occupation, a way to make a living rather than a means of service to others. Practicing medicine is a job like any other. There is no requirement to extend oneself beyond the job description. The ethics implicit on this kind of relationship is the ethic of the employee whose aim is to satisfy the patient so the patient will return and will recommend the physician to others. Only as much kindness and compassion as are needed for success need be offered. There is no commitment beyond strict working hours. Choice of physician is not important because physicians are interchangeable. The patient often is seen not as a personal responsibility of the physician, but of the organization.

The Physician as Social Servant

Another model increasingly being pressed upon today's profession is the physician as social servant, as primarily an instrument of societal, or fiscal, good. Medical knowledge is thus directed to some purpose beyond, in addition to, or along with, meeting the needs of the individual patients. Examples of this genre are the physician acting as rationer in a managed care system, physicians as employees of a penal institution, physicians in military service, and public health physicians. The physician's primary orientation is toward the good of the population in general, or a specific population in a social institution. The ethic implicit in this model is a population-based ethic. These are the roles of the physician as bureaucrat or functionary using medical knowledge for purposes other than the good of the individual patient.

The Physician as Helper and Healer

The most traditional model, and ethically the most demanding, is the model of the physician as helper and healer, a committed professional whose primary obligation is to the good of his patient.[31] In this model, the physician is committed to something other than self-interest, advancement of career or occupation, or even the good of society. This model is based ethically in the specificity of the role of

TABLE 1-1

MODELS OF THE PATIENT–PHYSICIAN RELATIONSHIP

MODEL	PHYSICIAN	PATIENT	ETHIC
Applied biology	Clinical scientist: uses knowledge to solve medical problems	Biological object harboring a disease	Good science, truth, objectivity, technical competence
Body repair	Body mechanic: fixes biological problems	Owner of defective body part	Technical competence, fulfillment of service contract
Commodity transaction	Businessman: competes for clients	Consumer of medicine and source of gain for the physician	Business, the laws of the marketplace
Investment opportunity	Businessman: views self as an entrepreneur	Unit of care, which can be sold or traded by contract	Competitive business, marketplace concerns, profit margins
Managed care industry	Businessman: functions as an employee	Client whose consumption of care must be controlled	Corporate goals, economic concerns
Social utility	Social servant: uses medicine as instrument of societal good	Client who is a societal subunit	Population-based needs of the many versus the individual
Professional	Helper, healer: uses medicine for the patient's benefit	Person to be helped	Covenant of trust

physician as healer, helper, and curer. This ideal is not always actualized to be sure, but it has been at the heart of the Hippocratic ethic and its many variations. It is the model that this chapter proposes as the foundation for the ethics of the healing professions.

Summary of the Models

Table 1-1 lists the models of patient–physician relationship that we have discussed in this chapter. These are models that are now in vogue and often competing for primacy. Each implies a different theory of medicine, a different interpersonal relationship between physician and patient, and a different ethic. In each of these models, except the healing model, the physician uses medical knowledge for what can be a good or bad purpose. These other purposes are not intrinsically evil, but neither are they distinctive of medicine because medicine is defined by its healing purpose. When purposes extrinsic to medicine, itself, conflict with the end of a healing relationship, ethical dilemmas arise in which priority must be given to patient welfare.[32] The nature of these conflicts (eg, the physician as military officer, public health official, or forensic psychiatrist) will be treated in other chapters. This chapter focuses on the "end" of medicine as medicine, on what distinguishes it as a special kind of human activity with its own internal morality.

HEALING AND HELPING: THE "END" OF MEDICINE

Medicine and physicians are a part of the social and historical fabric of the cultures within which they live and function. Medicine therefore is in part economics, business, societal purpose, and function. But it is not primarily any of these things. If a true foundation for medical ethics is to be found, it must be sought in what is unique to medicine, and this is the healing relationship between the patient and the physician. It is from this uniqueness that an ethic specific to medicine can be defined. The ethical implications of this uniqueness may be derived *externally*, by some form of social construction, or by applying some preexisting system of morals and ethics to the phenomena of medicine. Alternatively, the ethics of medicine may be derived *internally*, by a study of the phenomena of medicine itself. We will examine both approaches methodologically and substantively.

External Morality

An *externally* determined ethic is most often derived from a preexisting system of moral philosophy with origins outside medicine but applied to the activities peculiar to medicine. This is generally a "top-down" approach in which medical ethics draws upon principles, duties, or rules and action guidelines developed outside medicine to define morally appropriate conduct, or choices. Some examples are the derivation of duties of physicians and patients from the deontological ethic and categorical imperative of Immanuel Kant,[33] the principle of utility maximization of John Stuart Mill,[34] natural virtue ethics of Aristotle,[35] or the Christian virtues as exemplified in Thomas Aquinas.[36] Similarly, an external source of medical ethics might be drawn from a religious tradition, as in the theological ethics of Thomas Aquinas, the Catholic casuist tradition,[37] or an updated conception of natural law,[38] the Protestant tradition,[39] or the Jewish halakic tradition.[40,41]

In recent years, systems of externally derived ethics have had their origins in sociocultural mores, in social constructivism, or coherence theories. Here the justification for judgments of right and wrong are determined by societal consensus, or coherence with other accepted beliefs and principles, or by "reflective equilibrium," a dialogue between general principles and intuitive judgments.[42] Existential,[43] narrative,[44] caring,[45] and feminist ethics[46] are further examples of external systems for the derivation of right and wrong. These and other ethical theories have been applied to medicine to justify what ought and ought not to be done in particular clinical situations.

The foregoing "external" sources of medical ethics are formulated in other chapters in this book and will not be given further consideration here. In any contemporary study of medical ethics, they deserve serious consideration. They express moral truths of various relevance to, but not necessarily determinative of, right and good conduct for physicians and other health workers. They relate to, but are not determined in the first instance by, the nature of medicine as a special kind of human activity. In one way or another, they leave a gap between ethical theory and the realities of the moral world of physician and patient. To close this gap, it is necessary to move more closely into the lived worlds of physician and patient—to a more internally determined ethic.[47]

The Ethics Internal to Medicine

There are several senses in which an ethic may be *internal* to medicine. One is the ethic expressed in ethical codes elaborated within the profession by physicians, for physicians. Examples would be the Hippocratic Oath,[9(pp299–301)] the ethics of the Chinese physician,[48] the Indian Code,[49] the ethical "code" of Thomas Percival prepared for the physicians at the Manchester Infirmary,[50] the AMA Code of 1847, its many revisions since then, and their expansion in the Opinions of the Council on Ethical and Judicial Affairs of the AMA.[11] The ethical codes of the World Health Association, the British Medical Association, and a multitude of others would all be internal in this sense. These codes were prepared for, and by, members of the profession without significant input from those outside the profession.

These internal codes generally turn out to be statements of moral belief mixed with etiquette. They exhibit little in the way of formal "ethics," because their moral foundations are taken for granted and not derived or justified by analysis or argument. Their moral content is surprisingly similar to that expressed in the Hippocratic Oath and ethic. These codes all express certain moral truths that have shaped the ideals of professional behavior and the commitment of the community of physicians to patient welfare. They should not be discounted, as some suggest, simply because they were prepared *by* physicians and *for* physicians.[51] Their final test is not who composed them, but whether or not they contain arguable or demonstrable ethical truths.

Laws pertaining to medical practice are external to the internal morality of medicine. Laws are *external* because they promulgate statutes governing the obligations of physicians to patients, the source of which is legislative action outside of medicine. Nonetheless laws are responsive to the special nature of the medical relationship. The laws of torts, contracts, and fiduciaries, for example, recognize the special nature of the patient–physician relationship. In this latter sense, these laws accurately reflect the special nature of the therapeutic relationship and the vulnerability of patients who, as a result, are in need of legal protection. Laws governing medical practice, thus, get their moral force from their recognition of the realities of the patient–physician encounter.

Also situated somewhere between the internal and external boundaries of medicine are theories of ethics or models of the relationship with strong sociological and psychological foundations. One example would be Lain Entralgo's formulation of friendship *(philia)* as the foundation of the relationship.[24(p149)] Other examples would be the notion of caring, the patient's or physician's life story or narrative, or the experience of practice itself. Each concept has roots in the actualities of the patient–physician relationship; none is sufficient in itself to be the basis of a normative ethic for that relationship. Each is important but best incorporated in the view of a healing ethic.

Elements of an Internal Morality for Medicine

For purposes of this chapter, the term *internal morality* will be used more narrowly to signify a foundation for medical morality arising within the phenomena peculiar to medicine, those that define it as a special form of human activity, and by that fact generate specific moral responsibilities binding only on those who profess medicine or the other health professions. The three phenomena specific for the patient–physician relationship are: (1) the fact of illness; (2) the act of pro-fession; and (3) the act of medicine. Together they comprise the healing relationship, the end of which is the good of the patient.

The Fact of Illness

The most fundamental fact about medicine is that it exists because humans become ill. This and mortality are the two most universal characteristics of human existence. They transcend culture, history, and all other differences between and among humans. Illness is a subjective existential state in which the patient's sense of well-being or accommodation with existing disease is threatened or compromised by some new symptom or sign. The person who recognizes himself as ill enters a new stage of existence in which his humanity is diminished in several specific ways.

First, there is the loss of freedom to do what one wishes because of pain, disability, discomfort, and so forth. Being ill creates anxiety, fear of mortality, and disability. Illness may or may not correspond to objective pathology (ie, disease). Illness threatens the image of one's physical and emotional integrity. The illness then becomes a center of concern and diverts energy and attention from other pursuits. It creates a disorganization and disequilibrium of the whole of the person's existence.

Ill persons may tolerate this state of disequilibrium for a long time but ultimately most decide they need help. That is when they become *patients*— persons bearing a burden of suffering. (The word "patient" is derived from the Latin *patior, patiens, pati* meaning "to suffer, bear a burden."[52[pp1308–1309]]) When people become patients, they realize they need the knowledge and power of others to be healed. Patients then no longer treat themselves but are compelled to seek out a health professional in whom eventually they must place trust. They must enter a relationship of inequality because the health professional possesses the knowledge and skill the patient needs. Thus when well persons become ill, by that very fact, they become patients—vulnerable, suggestible, and exploitable. They experience a change in existential state that is not exactly parallel to any other state. Illness is a unique universal phenomenon of human existence and it is that uniqueness that generates its moral orientation.

The Act of Pro-Fession and Promise

In this special state of vulnerability, the patient seeks out someone who professes to be a healer. The physician or other health professional asks what is wrong: "How can I help?" In this question, physicians invite the patient's trust that they possess the requisite knowledge, that they will use it to help and not to harm (ie, to act in the patient's best interests, not their own, and not in the interests of others). When physicians voluntarily offer to help, they make an implicit promise. They offer themselves as healers, helpers, and caregivers. They generate expectations they promise implicitly to fulfill. They voluntarily bind themselves, by that very fact, to act beneficently. Their assigned societal role and their possession of special knowledge require them to help. Physicians thus automatically enter into a covenantal trust relationship when they offer to care for a patient. A covenant is more than a casual promise. It is a mutual agreement with something of the sacred about it because it is made in the presence of need by one capable of meeting that need.

This promise to help is an act of pro-fession ("profession" derives from the Latin *profiteor, profiteri* meaning "to acknowledge openly, to avow," and *professio*, "an open declaration of an intention"[52[pp1475–1476]]), that is to say, it is a solemn promise that binds *this* physician to *this* patient in a way that makes the physician an accomplice if harm comes from the relationship. The patient may dissolve this bond unilaterally by discharging the physician. But if the patient is ill, the physician can end the relationship only after another physician has agreed to undertake the patient's care.

The Act and End of Medicine

It is the act of healing, helping, and curing (which is what the patient seeks, needs, and expects from the physician's promise of help and the physician's invitation to trust) that initiated the relationship. Help, healing, care, or cure are the immediate ends of medicine. To be authentic, this end must be defined in terms of the good of the patient, that which restores health, if that is possible, or provides comfort and care if restoration of health is not possible. The *good* of the patient is a complex concept, multilayered and highly personalized. It consists of at least four components: (1) the medical good, (2) the good as perceived by the patient, (3) the good of the patient as a human, and (4) the good of the patient's spiritual nature.[53]

The first (and lowest on the scale) component is the medical good—that which the competent application of medical knowledge can achieve—treatment, cure, comfort, or containment of the disease. This is the most objective level susceptible to scientific apprehension. It is the level at which diagnosis, prognosis, and therapy function.

The second component of the patient's good is the good as perceived by the patient—what constitutes a "quality" life, the trade-offs the patient may wish to make among the options for treatment, the amount of risk, pain, discomfort, and disability that will be accepted as a price of treatment. The patient's perception of good is subjective, individualized, and personalized. It may or may not correspond with the medical good as perceived by the physician. It can only be defined by the patient.

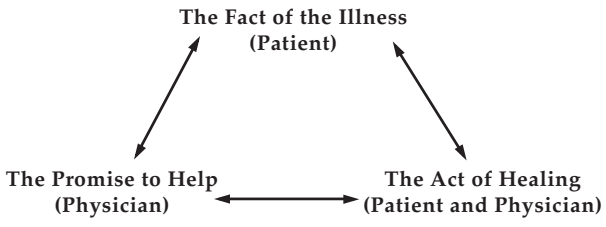
The third component of patient good is more general. It is the good of the patient as a human being, as a being with inherent dignity possessed of reason and will, free to choose, to plan one's own life with a minimum of coercion by others or by events. It is this inherent dignity that entitles all humans to respect for their own decisions and it is from this good for humans that the principle of autonomy derives. Justice, likewise, is grounded in who and what we are, as possessors of a common humanity. Justice requires equal treatment of patients and retribution for harm done to them. Keeping promises, such as the physician's promise of healing and helping, is also a matter of justice—something owed to all persons.

The fourth component, and the highest good of the patient, is whatever pertains to that individual's

spiritual nature—beliefs about the nature and destiny of human life, its meanings, purposes, and relationships to sources of morality beyond human determination. This good is also grounded in our humanity as beings capable of commitments to ideals and beliefs beyond the needs of our material bodies. This is the realm of religious belief, or nonbelief, the ultimate source of morality for most patients when confronted with their own finitude, suffering, or despair. It is also the ultimate source of morality for many physicians.

The immediate telos, or end, of medicine is to advance the good of a particular patient on all of these four levels. This is what healing means, that is, to help the patient heal himself, to become whole again to the extent possible within the limitations imposed by the patho- or psychophysiological aberration that brought him to the physician in the first place. To achieve this end will require in the immediate term a *right* and *good* decision, one which is scientifically and technically correct, and one which conforms with the four levels of good as they present in *this* patient. Morally valid medical and clinical decisions therefore fuse the technical and the moral dimensions in the moment of clinical decision. It is through the immediate end of a right and good decision made with, and for, the patient that the broader end of healing, and ultimately, the even broader ends of health of the individual and of society are attained.

A right and good decision must also be carried out safely, efficiently, prudently, and with a minimum of pain and discomfort. These obligations arise out of the seriousness of the promise to protect and advance the well-being of the patient. The vulnerability of the patient, and the trust patients must ultimately place in the physician's skill, are the foundation for the obligation to be competent in performance as well as in knowledge. Competence in psychomotor skills is, therefore, a moral requirement. Thus the internal morality of medicine rests on the relationships of three phenomena that characterize the clinical encounter: the fact of illness, the promise to help, and the healing act of medicine. Schematically, they can be represented in this way:



These are the ineradicable phenomena of the human experiences of being ill, being healed, and professing to heal. They are universal human phenomena. No matter which culture, historical era, or national boundaries frame them, they are the same. They are the same phenomena experienced by ancient Greek patients and their physicians as well as today's patients and physicians. They will be the same in the next millennium and beyond because they are elements of the human condition. Medicine will become more highly technical than it is now, and more will be done by computers and automated means of diagnosis and treatment, but the need of sick persons for human interaction, intercession, and counsel will remain. Indeed, as machines take over the procedures of medicine, the need for the human touch and the ethical dimension of clinical decisions will be correspondingly greater.

The Clinical Encounter

Principles and Duties

Up to this point I have distinguished *external* morality, as any system of ethics derived from outside of medicine (like the ethics of Aristotle, Kant, Hume, and Beauchamp and Childress), from *internal* morality, the derivation of duties, obligations, and principles from the phenomenology of medicine itself. However, the internal morality of medicine is not disconnected from the specific principles, rules, guidelines, and virtues that characterize external systems of morality applied to medicine. The difference in an internal morality is that they are derived from the empirical phenomena of the clinical encounter. They are, therefore, not dependent upon preexisting ethical theory or the resolution of disagreements between and among these theories.

The four principles of Beauchamp and Childress[54] (ie, beneficence, nonmaleficence, autonomy, and justice) are one example of an external theory of medical morality that can be grounded more securely in the empirical realities of the clinical encounter. These principles have a firm foundation because they are necessary to achieve the end of medicine and fulfill the covenant of trust. Thus beneficence and nonmaleficence become duties because they are promised when the physician offers to help in the way specific to his profession. They are prima facie principles because no patient seeks professional help to be harmed; patients seek to be helped. No one expects to be used to advance the physician's or someone else's good. Subjects in clini-

cal research may give free and informed consent to participation to advance the good of others but even the experimental subject's good must always be protected.

Autonomy, as argued above, is a good of the patient as a human being. It is one of the distinguishing characteristics of being human that we can make plans, make choices, and control significant parts of our lives. To ignore, override, or manipulate this decision-making capacity is to violate the good of the patient, to create harm and thus to defeat the end of medicine, which is healing and not harming. To violate autonomy is thus a maleficent act. Beneficence, nonmaleficence, and autonomy are not in opposition but reenforce each other. Autonomy is not absolute, however. The conditions that restrict are subjects for other chapters.

Justice, like autonomy, is a good of the patient as a human being. To violate justice is to violate an essential feature of human existence (ie, what is owed to each human simply by virtue of being human). Like violations of beneficence and autonomy, violations of justice are maleficent and, therefore, frustrations of the end of medicine, which is the good of patients.

The Virtuous Physician

Like the prima facie principles of medical ethics, the virtues physicians should exhibit are linked to the ends of medicine and the phenomena that characterize the healing relationship. Virtues in general are defined as "the state of character which makes a man good and which makes him do his own work well."[55(1106a:22–24)] When the concept of virtue is incorporated into medical ethics, it refers more specifically to those traits of character that make a physician or nurse (or other health worker) a *good* physician or nurse—one whose intention and action optimizes attainment of the ends of the healing relationship.[56]

Essential to the notion of a virtue from its earliest definition in Plato and Aristotle is the idea of perfection *(areté)* in achieving a purpose. The virtuous physician or nurse is one who exhibits excellence in those character traits that enable one to come as close as possible to the healing purposes of the patient–physician (or patient–nurse) relationship. There are certain virtues or character traits that are particularly crucial; indeed, so crucial that they are entailed by the ends of medicine and without them those ends cannot be achieved. Some of these virtues are as follows[57]:

- *Fidelity* to trust is inescapable in the real world of a sick person seeking help. Without trust in the good intention of the physician and the physician's capability to perform competently, healing becomes difficult or impossible. The physician invites trust and must therefore be faithful to that trust, lest the offer to help be a lie and a deception.
- *Benevolence*, namely the predisposition habitually to wish to act for the patient's good, is the virtue that disposes the physician to do good, specifically to do good *for* the patient. This disposition is present even when it costs the physician something in time, frustration, loss of income, interference with personal plans, and so forth. Benevolence is a requisite virtue even in those difficult and frustrating cases of patient noncompliance, or abuse of health practices, or nonpayment of legitimate bills for service.
- Benevolence entails another virtue, namely *effacement of self-interest*. This is the disposition to serve the good of the patient even at some loss of personal self-interest. This virtue has limits. But where those limits are set is a highly personal matter. Heroic sacrifice is not required, but some degree of self-effacement is essential to attaining the ends of medicine. Without it a professional loses that which distinguishes his work from a mere occupation.
- *Compassion and caring* are equally relevant virtues. Compassion as a virtue is the habitual disposition to enter into the predicament of the sick person, to feel something of that predicament with him, and, as a result, to wish to help. Without entering the patient's predicament to some extent, it is not possible to heal in any full sense of that term. Care is a virtue closely related to the virtue of compassion. It may mean caring for the patient, that is, taking a personal interest in the patient's fate, or taking care in the way we carry out our professional duties, or taking care of the patient's need and concerns. However interpreted, caring is an essential virtue integral to any morally satisfactory healing relationship. It is not, however, sufficient by itself to constitute a normative theory of ethics.
- Both care and compassion must be combined with *objectivity* if they are not to be harmful. Objectivity allows for an assess-

ment of the actual physical state, diagnosis, and prognosis. It is united with compassion by putting all the factual data into the lived world, life situation of *this* patient. Objectivity and compassion complement and balance each other.

- *Courage* is one of the four cardinal virtues from antiquity (the other three being temperance, justice, and prudence). It disposes physicians to take the personal risks necessary to care for the sick in times of emergency, disaster, or war; to expose oneself to contagion when necessary; and to take a moral stand when cooperation with what is morally wrong must be resisted.
- *Intellectual honesty* is a virtue insufficiently emphasized. Medicine and medical knowledge are powerful tools. They can be used for good and harm, or for control over others. Recognizing what one does not know, admitting it to oneself, to the patient, and to one's colleagues, is an essential safeguard for the vulnerable patient. Intellectual honesty is the antidote to the vice of intellectual hubris to which all professionals, and especially physicians, are so easily prone.
- In addition to intellectual honesty, a more general disposition to *humility* is required. This lies in a sober appreciation of the limitation of medicine as art and science, and of the physician, himself as an instrument of the patient's healing. It is an awesome thing to offer oneself to help or "heal" another. Merely to contemplate the demands on the health professional's knowledge, compassion, and understanding of the predicament of illness is to impart a sense of unworthiness on any responsible professional. Nonetheless, it is through fallible human beings that the knowledge and skill of medicine must be employed if the sick are to be helped. Physicians and other health professionals cannot permit themselves to be overwhelmed by their importance, nor by their sense of impotence and inadequacy. What humility requires is a calm and moderate assessment of the dangers of both indecision and presumption. A knowledge of the limitations of one's own person and of the art, itself, is gained only by careful, sustained, lifelong self-examination of the potential for good and harm in arrogating to oneself the title of "physician," "nurse," "psychologist," "social worker," and so forth.
- *Finally, and one of the most important of the clinical virtues, is prudence.* This is not the modern exercise of self-protective caution, which avoids risks to one's own welfare and does not venture to do good if it means a loss of self-interest. Phronesis, the Greek word for prudent judgment or practical wisdom, was, for Aristotle and Aquinas, the link between the intellectual (the capacity to know) and the moral virtues (the capacity to act well).[55(1144b30–1145a6),58,59] It encompassed the capacity of practical wisdom, knowing how to choose the appropriate means in a complicated situation so as best to serve the good ends of the healing relationship. Prudence is the power of discernment. In the clinical context it is akin to clinical judgment—knowing how, when, and in what way, to act in the face of uncertainty, in a situation we have never encountered before, or one in which the virtues themselves appear in conflict.

Obviously, there are other character traits that can be entailed by the realities and ends of the patient–physician relationship but these just listed are indispensable. In their absence it would be difficult or impossible to assure a healing relationship that met minimum standards of ethical propriety.

Virtues do not by themselves constitute a whole moral philosophy for medicine.[60] They lack the specificity and concreteness of principles, rules, and axioms as action guidelines. Virtues also are subject to a multiplicity of definitions and orderings. They may conflict with each other because they are tied to the definition of the patient's good, and there may be differences about how to define that good for, and with, a particular patient. The tendency to subjectivism is accentuated by the circularity of the logic that ordinarily accompanies virtue theories, that is, virtuous persons do what is good; the good is what virtuous persons do. However, by grounding the virtues in the empirical realities of the patient–physician relationship we can avoid some of this circularity and most of the shortcomings of virtue theory in general.

The Virtuous Patient

The ethics of any human relationship implies reciprocal duties, principles, and virtues. In medical

ethics, it is the duties of physicians that are emphasized. Given the balance of power in the physician's favor and the vulnerability of the patient, this is the morally proper ordering. Nonetheless, some mention of the patient's obligations and virtues is necessary if a full account of the internal morality of the healing relationship is to be provided.

If the end of medicine is to be attained, patients must participate in their own healing, and must facilitate the physician's pursuit of this end. This requires, at a minimum, that patients must be honest in the facts they provide in their histories of their illness. They must not withhold, misrepresent, or manipulate the facts for some ulterior motive. Patients should also cooperate in carrying out the treatment plan by following directions and reporting changes promptly. Without this minimal cooperation, the physician cannot fulfill his moral obligation to attain the healing ends of medicine.

People, in addition, have responsibilities to preserve health even before they become patients. Smoking, dietary and alcohol excesses, sedentary habits, failure to receive appropriate vaccinations, and similar behaviors thwart the "end" of medicine. Moderation (or temperance as it is sometimes called), another of the ancient cardinal virtues, is a requisite virtue on the part of patients if health is to be maintained and the effects of disease are to be mitigated or prevented.

Failures on the patient's part are, however, not ipso facto a warrant for refusing to treat the patient who does become ill by failing to follow the physician's advice or because of poor health behavior. Physicians are not judges of the patient's virtue and are not empowered to punish patients by withholding their ministrations.

Patient autonomy is not absolute, however. The good of the physician as a human being entitles him to respect for his autonomy as well as the patient. Thus, if a patient requests a treatment that is futile, violates the canons of rational medicine or the religious beliefs of the physician, or poses a definable, grave, and probable harm to an identifiable third person, the physician is obliged to refuse. The physician, unless discharged by the patient, may withdraw from care of a sick person only when another physician whose values are more congruent with the patient's is willing to assume care. Until that time, the physician must care for the patient but must also do so in accord with his own conscience. The physician is a moral agent and as such must take responsibility for his actions.

When no emergency is present, physicians may refuse to care for a patient who threatens physical harm to others, consistently violates the physician's instructions, or endangers the life of the physician. Examples would be the violent drug addict, the sociopath, or the psychotic paranoid patient who threatens the physician or the physician's staff. Withdrawal can also be justified when the patient's repeated behavior makes achievement of the ends or purposes of medicine totally impossible. This decision must be taken with caution, without vindictiveness, and with a readiness to help again if the patient changes this behavior or presents in an emergency seeking assistance.

Another reciprocal duty of patients is to recognize their own finitude. There is a point in the natural history of any serious illness at which it becomes futile to continue, or to add, treatments. Hippocrates recognized this patient obligation when he said that patients should not expect medicine to cure them when they are overmastered by the disease.[61] This can now be stated as a principle: There is no obligation to treat when treatment is futile (in other words, ineffective, nonbeneficial, or overly burdensome in relation to benefit or effect). This is an obligation too often ignored by patients and families who demand that *everything* be done even when death is inevitable, the patient is in a permanent vegetative state, and further treatment is without value, or when the burdens outweigh the benefits. Physicians and patients have mutual obligations to recognize when treatment is no longer effective or beneficial. Together they should then decide to desist from treatment.

Medical Ethics and Social Responsibility

This chapter has focused on the individual patient–physician relationship. Other chapters will deal with institutional and social roles. However, it is important to indicate that this emphasis on the *internal* morality of medicine does not preclude, nor excuse, physicians from societal obligations. The physician is a steward of medical knowledge who has been allowed certain privileges by society in the course of caring for sick persons. These privileges include hearing confidential information, seeing and touching patient bodies (sometimes in very intimate ways), as well as performing surgical procedures and using controlled substances to alleviate suffering. Acceptance of the privileges of a medical education and possession of medical knowledge generates obligations to make them available for the betterment of society. Medical students enter into a similar covenant with society when they accept the privileges of a medical education. These privileges

include the right to dissect human tissue, to participate in the care of patients as a student or resident, and to learn to carry out medical procedures. These privileges are sanctioned by society so that a continuous supply of medically trained personnel can be assured for society.

Ethical issues arise when the physician is forced to choose between the good of an individual patient and the needs of the society. Specific conflicts of this kind as they occur in the military service and in battle conditions constitute a large part of this textbook and will not be covered here. Suffice it to say that except in the most extreme exigencies, the physician remains a physician always. To depart from the internal morality of medicine is to repudiate what it is to be a physician. Persons who enter any kind of relationship with a physician expect, and have a right to expect, fidelity to the fundamental ethic of the profession. Any compromise with this expectation for reasons of social or national exigency must be closely scrutinized if medicine and physicians are not to be used as means to political, social, or economic purposes not their own.

Managed care is becoming a paradigm case of this issue. Physicians in managed care are urged to become *gatekeepers*, to act as agents to conserve society's resources, and to take the needs of other patients into account in deciding who gets what care, and how much. Presumably physicians are expected to deny needed care so that those more needful may have access to that care (eg, to pay for child health, to extend coverage to the uninsured), or to cut costs and yield profits for investors.

On the covenant model of medical ethics detailed in this chapter, physicians should not act as gatekeepers. If there must be rationing, then it should be *explicit* rationing, that is, rationing through decisions on benefits made societally but not by individual physicians in individual cases. All patients need to know the limitations society places on their care. With explicit rationing physicians can still serve the patient's interest within the confines of externally imposed limitations. But with explicit as with implicit rationing, the physician must reserve the right to refuse to obey a social policy if it is harmful to his patient.

Physicians should make a societal contribution to cost containment. First, they must practice the most rational medicine, providing only what is effective, beneficial, and not excessively burdensome. When two treatments are equally effective, the less expensive should be chosen. Another way to contribute to societal welfare is to provide expert testimony to policy makers so that benefit packages can be based on effectiveness and benefit, not cost. A third way is to act together as a profession for the welfare of the sick, especially for the underprivileged, the poor, the disabled, and the elderly who do not fare well in market and competition-driven managed care plans. Finally, as a citizen, the physician has a duty to be informed of public policy, and to foster the welfare of the sick through lobbying for appropriate public policy. There will be times in managed care organizations when the pressure on physicians to serve interests other than those of their patients will so damage the trust relationship that virtuous physicians have a duty to refuse.

Medical Ethics, Culture, and History

Some may object that in a culturally pluralistic world like ours, the idea of a stable foundation for medical ethics binding on all physicians across national and cultural boundaries is an anachronism. It is true that responses to illness and disease by patients, physicians, and societies may vary widely. People in different times and cultures have different attitudes and behaviors in the presence of pain, suffering, and death. They value human life itself and the lives of the aged, disabled, or unborn in different ways. Their interpretation of the meanings and origins of illness vary, as do their therapeutic endeavors.

The same is true in ethics. The emphasis on autonomy, truth telling, and confidentiality is closely bound to Anglo-American beliefs in individual freedom, privacy, and self-determination.[62,63] In other cultures, decisions may be made by families, tribal chieftains, or by community discussion. Infanticide, abortion, and the rights of women may vary with historical era, ethnicity, or religious belief.

In the minds of some, all of these differences militate against the possibility of a universal ethic of medicine. Medical ethics, they would say, is whatever we make it to be. It can be socially constructed differently in different societies and times. What is morally right for one may be wrong for another. Pluralism is a fact and it is anachronistic to seek a common foundation even for medical ethics. This is the thrust of antifoundationalism, the trend of so-called postmodern philosophy and ethics that denies the possibility of any stable set of moral precepts.

In medicine, at least, antifoundationalism flies in the face of the human experience of illness, which is common across cultures and time. The phenomena do not change. They are common to humans

whether they lived in ancient Greece, live in the United States today, or will live in a space station in the future. A broken leg, a crushing chest pain, spitting blood, or chills and fever induce anxiety, fear, distress, vulnerability, and a need and call for help. The Hippocratic physician, today's internist, tomorrow's flight surgeon on a space station, or the shaman in a distant era or country, each confronts a human in need of help. The methods may differ, but the end of medicine is the same in each case: healing, helping, relieving pain and anxiety, and curing when possible. These phenomena of being ill, being healed, and healing, itself, transcend time and culture. They ground the ethics of the patient–physician relationship in universal human experiences even though cultural and historical settings may differ.

A Common Ethics for the Health Professions

This chapter has concentrated on the ethics of the profession of medicine. Only analogically has it touched the ethics of the other health professions such as nursing, dentistry, medical social work, clinical psychology, pharmacy, and allied health. Each of these clinical professions confronts human beings in the state of illness; each deals with the same fundamental phenomena of illness and healing. The same virtues, principles, and duties that bind the physician bind these other clinicians in their clinical encounters with sick persons seeking help.

The common foundation for the ethics of the health professions is the empirical reality of the human relationship between patients and health professionals—the *internal* morality described above. This common ground of empirical fact speaks for a common ethic of the clinical healing relationship. To be sure, upon this common base there will be certain additional obligations specific to each profession, and expressed in their different codes of professional ethics. But a common thread runs through all these codes. The ethics of the healing relationship is, in the end, the general ethic of the health professions. Its foundation will be the same for physicians, nurses, dentists, social workers, psychologists, allied health professionals, and healthcare administrators. That foundation will be, as always, the varied phenomena of the human encounter between one human in distress seeking help from another who professes willingness to help, possesses the technical and moral skill to do so, and promises to use them for the good of the person seeking help.

CONCLUSION

In the chapters immediately following this one, the rich theoretical foundation for the patient–physician relationship will be explored, with a particular focus on the clinical setting. Then, using the tools of research methodology, we will explore the many overall influences on the patient–physician relationship.

This chapter opened by noting that medical ethics begins and ends in the patient–physician relationship, whether that is in a civilian or military setting. Thus the point was made that in many respects military physicians do not differ from their civilian medical counterparts. The military physician, as a physician, is distinguished from other military personnel by his engagement in a special kind of human relationship that, of its nature, demands a certain level of moral commitment. That commitment must be the determinant of the physician's conduct even in the extraordinary circumstances of national defense and war. The extent to which these exigencies may shape those moral commitments is explored in the many other chapters in this work on the subject of military medical ethics. What is inescapable is the fact that the physician cannot avoid complicity if harm comes to his or her patient. The good of the patient is, as always, the gold standard of moral propriety.

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